

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06884 P

CERTIFICATE OF DEATH

Reg. Dist. No. 94a

1. PLACE OF DEATH:

County

City or town

Capitol
Springfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Springfield State Hosp.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

M

W

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

77 7 6 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. William Jefferson Martin

13. Birthplace

Baltimore

14. Maiden name

Alice Spence

15. Birthplace

Baltimore

16. Informant

Mrs. Harold H. Martin

Address

11 Sunbeam Park

17. Cemetery or crematory

Burial, cremation, or removal (Yes/No)

Date of death

(month) (day) (year)

Cemetery or crematory

St. Peter's Cemetery

18. Funeral director

John A. Martin

Address

3000 E. Belts H

19. (Date rec'd by registrar)

Aug. 5 1947

A. W. Melvin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns, infants give residence of mother)

State

Md

City or town

Baltimore

Street No.

1100

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 4th 1947 at 8:40 a.m.

Sept 26 1947 to Aug 4th 1947

and that I last saw her alive on Aug 4th 1947

Immediate cause of death

Coronary Occlusion 1 hr

Due to

and Arterialclerosis 10 yrs

Due to

Hypertension 18 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... M. L. or other

Address..... Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06885

CERTIFICATE OF DEATH

Reg. Dist. No. 72

93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County..... Carroll
City or town..... Westminster, R.D.1 Myers District.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?.....

3. (a) FULL NAME

Howard Lafayette Bechtel

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Lillie (Null) Bechtel

7. Birth date of deceased (mo., day, yr.)..... May 10 1873 6. (c) If alive, give age..... Dead years

8. AGE: Years..... 74 Months..... 2 Days..... 22 If less than one day..... hrs..... min.....

9. Birthplace..... Carroll County, Md. (Town, county, and state)

10. Usual occupation..... Farming

11. Industry or business..... Farm

12. Name..... Henry Bechtel

13. Birthplace..... Carroll County, Md.

14. Maiden name..... Martha Rebecca Bowersox

15. Birthplace..... Carroll County, Md.

16. Informant..... Kenneth P. Bechtel

Address..... Westminster, Md. R. D. 1

17. Burial..... Date thereof..... 8/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Bartholomew Cemetery,

Location..... York County, Pa.

18. Funeral director..... J. M. Little & Son

Address..... Littlestown, Pa. Per R. A. Little

19. Aug. 4th..... 19. 47 (Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State..... Maryland County..... Carroll
City or town..... Westminster, R.D.1 Myers District
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 2 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 1946 to Aug 2 1947 and that I last saw him dead on Aug 2 1947

Immediate cause of death..... Cerambyx & exclusion

DURATION

1 hr

Due to..... arterio sclerosis & myocardial degeneration

1 mo

Due to..... beginning deceneration

1 mo

Other conditions..... Hypertrophy

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Howard Bechtel

M. D. or other

Address..... Westminster, Md. Date signed..... 8/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06886

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County

Carroll

City or town

Hampstead (Rural)

How long in above place of death?

104 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julia A. Belt

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Audrey J. Belt

7. Birth date of deceased (mo., day, yr.)

August 22-1857

6. (c) If alive, give age years

8. AGE:

Years
90

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

John Keck

12. Name

John Keck

13. Birthplace

Germany

14. Maiden name

Magdalena Keck

15. Birthplace

Germany

16. Informant

My Frank Stiegell

Address

Hampstead Md

17. Burial

Date thereof Sept. 3/47

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

St. Paul's

Location

Aspinwall Md

18. Funeral director

Edwin Tipton

Address

Hampstead Md

19. Sept. 2

1947

(Date rec'd by registrar)

John S. Hughes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town Hampstead Rural

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 31

19

47 at 1:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 26 1947 to Aug. 31 1947

19

19 47

and that I last saw her alive on Aug. 31 1947

19

19 47

Immediate cause of death

congestive heart

failure

Due to hypertension

Cardio-Vascular Disease

DURATION

4 weeks

10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Partufied M. D. or other

Address: Hampstead, Md Date signed: Sept. 1-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06887

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County Henryton, Md.

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2mos. 3 wks. 5 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Henryton

How long in hospital or institution?

3. (a) FULL NAME

Samuel Bolling

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

colored

Married

Katie Bolling

6.(b) Name of husband or wife

52

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

NOV. 22, 1889

8. AGE:

Years

57

Months

9

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Retired Goverment Employee

10. Usual occupation

11. Industry or business

William B Bolling

12. Name

MOTHER FATHER

Mississippi

13. Birthplace

Elmira Simmons

14. Maiden name

Mississippi

15. Birthplace

Patient

16. Informant

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 26, 1947

(month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Arlington, Virginia

18. Funeral director

Klimy J. Washington & Sons

Address

467 N St. N.W. Wash. D.C.

August 22 47

(Date rec'd by registrar)

Local Deputy

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Prince George's

Washington (P.O.)

City or town. (If outside city or town limits, write RURAL and give nearest town)

Street No. 5404 Sheriff Rd. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22 47 3:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1947, to Aug. 22, 1947, and that I last saw him alive on Aug. 22, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Sept. 1940

Due to

Due to

Other conditions

(Include pregnancy, within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

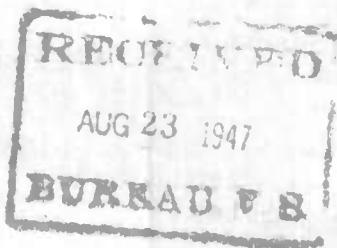
Means of injury

Injured at work?

23. SIGNATURE

Rudolf Hoffman, M.D. M.D. or other

Address Henryton, Md. Date signed 8/22/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06888

CERTIFICATE OF DEATH

57d
Reg. Dist. No. 75

1. PLACE OF DEATH

County

Carroll

City or town. Westminister Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

32 yrs.

Hospital, institution, or street address where death occurred:

Near Manchester Md.

How long in hospital or institution?

3. (a) FULL NAME

Harry Cleveland Bollinger

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Hattie V. Bollinger.

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.)

July 8, 1889

8. AGE:

Years

Months

Days

If less than one day

58

1

22

hrs.

min.

9. Birthplace

Rayville Md

(Town, county, and state)

10. Usual occupation

Cigar maker

11. Industry or business

General

12. Name

George Bollinger

13. Birthplace

Maryland

14. Maiden name

Eliza Wilhelm

15. Birthplace

Maryland

16. Informant

Yes Hattie Grove Bollinger

Address

Westminister Md.

17. Burial

Burial, cremation, or removal, which?

Date thereof 9 3 1947
(month) (day) (year)

Cemetery or cemetery

Union Cemetery

Location

York St Manchester Md

18. Funeral director

David P. Martin

Address

Manchester Md

19. (Date rec'd by registrar)

Sept. 7 1947 Mrs. H. P. L. Deemer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland

County

Carroll

City or town. Westminister Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Manchester Md

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947 at 11 P.M.

21. IDENTIFY that death occurred on the date above stated; that I attended deceased from

July 2 1943 to Aug 30 1947

and that I last saw him alive on Aug 30 1947

Immediate cause of death.

Cerebral Hemorrhage 48 hrs

Due to

Tumor of Brain?

Due to

Unknown if benign or malignant.
Was not operated upon.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE

Joseph E. Bush MD M. D. or other

Address. Manchester Md Date signed 8-30-47

RECEIVED

SEP 8 1947

BUREAU

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138
06889

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County.....

Maryland

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 15 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution?.....

3. (a) FULL NAME

OSCAR BOND

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

colored

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) -

January 3, 1892

8. AGE:

Years

Months

Days

If less than one day

55

6

11

hrs.

min.

9. Birthplace.....

Unity, Md.

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

Charles Bond

MOTHER FATHER

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Annie Hall

15. Birthplace.....

Unknown

16. Informant.....

Deceased

Address

Burial

Date thereof.....

8/18/47
(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

Catoonsville, Md.

18. Funeral director.....

Mrs. Francis H. Hensley

Address

598 W. Buddle St.

19. (Date rec'd by registrar)

8/14/47

19. 47

Albert R. Smith

Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Baltimore

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

24 Main Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

218-03-7629

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 14,

19. 47 at 1.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29, 19. 43, to Aug. 14, 19. 47

and that I last saw him alive on August 14, 19. 47

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

March 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Ruthie Hoffman, M.D.

M. D. or other

Address.....

Henryton, Md.

Date signed

8/14/47

RECEIVED

AUG 19 1941

BUREAU of

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06890

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:

County CarrollCity or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 5 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

JOHN MATHEWS BOYCE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

colored

single

6.(b) Name of husband or wife.....

..... 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 5, 1927

8. AGE:

Years 20Months 5Days 10

If less than one day

hrs.min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Scholar

11. Industry or business

MOTHER FATHER

12. Name Donald Boyce13. Birthplace West Indies14. Maiden name Wilhelminia Griffin15. Birthplace West Indies16. Informant PatientAddress Burial17. (Burial, cremation, or removal, which?) Burial Date thereof Aug 18 1947

(month) (day) (year)

Cemetery or crematory Henryton Memorial ParkLocation Foothills18. Funeral director John H. YoungAddress 1216 N. Caroline St.19. 8/15 19 47 (Date rec'd by registrar)Alfred P. Smolka
Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 1419 E. Madison Street

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1947 12.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1947 to Aug. 15, 1947and that I last saw him alive on August 15, 1947

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan.1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

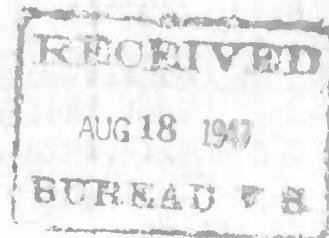
Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 8/15/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06891

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 77

1. PLACE OF DEATH

County

Carroll

City or town

Greenmount Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna May. Brodbeck.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widow

6. (b) Name of husband or wife

John H. Brodbeck

7. Birth date of

deceased (mo., day, yr.) December 8, 1879

6. (c) If deceased years

8. AGE:

Years Months Days If less than one day

68

8

23

hrs. min.

9. Birthplace

Greenmount Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Thomas M. Bostick

13. Birthplace

Maryland

14. Maiden name

Anna Williams

15. Birthplace

Maryland

16. Informant

Harry J. Brodbeck

Address

Greenmount, Md

17. Burial

Date thereof 9-3-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bemetary

Location

Greenmount, Md.

18. Funeral director

Jacob Winkler Sons

Address

Manchester, Md.

19. Date rec'd by registrar

Sept 2 1947

John S. Hughes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Greenmount Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 31 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1947 to August 31 1947

and that I last saw her alive on August 30 1947

Immediate cause of death

Chronic Myocarditis

Due to

Arterio-sclerotic Cardio-vascular

Disease.

Due to

Senile dementia

Other conditions

4 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work

Means of injury

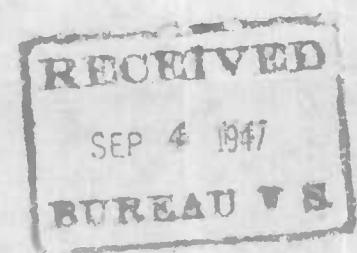
Injured at work

23. SIGNATURE

M. D. or other

Address

Olympia Md Date signed 8-31-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06892

CERTIFICATE OF DEATH

Reg. Distr. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos. 20 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

Norman Brown

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male col. single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1924

8. AGE: Years Months Days If less than one day
22 80 18 hrs. min.9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business

12. Name John Brown

13. Birthplace Madison, Maryland

14. Maiden name Ethel King

15. Birthplace Madison, Maryland

16. Informant John Brown - Father

Address 23 Douglas St. Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Cemetery Date thereof 8-30-47
(month) (day) (year)

Cemetery Cemetery

Location Cambridge, Md.

18. Funeral director Lewis & Seymour

Address Cambridge, Md.

19. August 26, 47 (Date rec'd by registrar) Albert P. Amerson
Local D-puty Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Douglas Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6 1946 to August 26 1947

and that I last saw h. im. alive on August 26 1947

Immediate cause of death

Progressive Primaryis Thc.

DURATION

June

1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

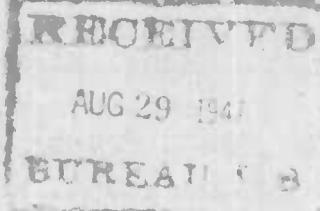
Means of injury

Injured at work?

23. SIGNATURE Nathan W. Brown, M.D.

M. D. or other

Address Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06893

CERTIFICATE OF DEATH

83a
81
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

(If rural, give LOCATION)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 7 1947 at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 7 1947 to Aug 7 1947 and that I last saw h. alive on Aug 7 1947

Immediate cause of death.....

.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06894

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 4 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

3. (a) FULL NAME

ELLA VIRGINIA CROMWELL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

colored

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

October 3, 1931

8. AGE:

Years

Months

Days

If less than one day

15

10

7

hrs.

min.

9. Birthplace: Annapolis, Md.

(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

12. Name: Abraham Cromwell

13. Birthplace: Maryland

14. Maiden name: Etta Hayes

15. Birthplace: Maryland

16. Informant: Etta Cromwell

Address: R.F.D. Box 54, Annapolis, Md.

17. Burial: Date thereof: 8/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Broadneck

Location: St. Margaret's Rd.

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. 8/10 1947 Alton R. Brantley
(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: aa

City or town: Skedmore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 2, Box 54, (Annapolis, Md.)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1947 at 12.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1947, to Aug. 10, 1947, and that I last saw her alive on August 10, 1947.

Immediate cause of death:

Pulmonary Tuberculosis

DURATION

July 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.

M. D. or other

Address: Henryton, Md. Date signed: 8/10/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06895

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Carroll

City or town

Manchester Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HELEN LaRue Earhart.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Norman DeWitt Earhart.

6. (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.)

February 19, 1914

8. AGE:

Years 33 Months 5 Days 25 If less than one day hrs. min.

9. Birthplace

Manchester Maryland

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

HOME

12. Name

Howard H. Loats

13. Birthplace

Maryland

14. Maiden name

Anne Virginia Hively

15. Birthplace

Maryland

16. Informant

Norman DeWitt Earhart

Address

Manchester MD

17. Burial

(Burial, cremation, or removal. Which?) Cemetery

Date thereof 8-10-47
(month) (day) (year)

Cemetery or crematory

Manchester MD

Location

Manchester MD

18. Funeral director

Jacob Wyrko Sons

Address

Manchester MD

19. Aug. 9

(Date rec'd by registrar) 1947

M. W. H. P. S. Deemer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

213-05-1578

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 11 1944 to August 8 1947

and that I last saw her alive on August 7 1947

Immediate cause of death

Hemorrhage Cerebral?

Due to

Primary Cancer?

Due to Cervix?

DURATION

Primary Cancer?

Cervix?

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Cancer?

Date of Oct 12 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

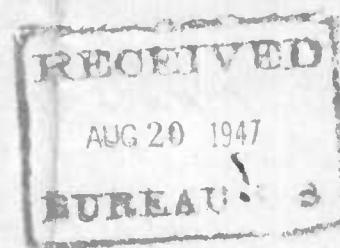
Means of injury

Injured at work

23. SIGNATURE Joseph E. Bush, M.D.

M. D. or other

Address 1300 Chestnut St. Date signed 8-8-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d 76

1. PLACE OF DEATH:

County..... Carroll
City or town..... Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

George W. Frizell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

widowed

6. (b) Name of husband or wife.....

Mary E. Frizell

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 18, 1862

8. AGE:

Years

Months

Days

If less than one day

84

8

6

hrs.

min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Publisher (retired)

11. Industry or business

12. Name.....

John Frizell

13. Birthplace

Maryland

14. Maiden name.....

Caroline Wright

15. Birthplace

Maryland

16. Informant.....

Mrs. Harry C. Bond

Address

Washington, D. C.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof..... 8/27/47

(month) (day) (year)

Cemetery or crematory.....

Westminster Cemetery

Location.....

Westminster, Md.

18. Funeral director.....

J. Francis Reese

Address

Westminster, Md.

19. (Date rec'd by registrar)

19-

7-47

H. W. Billingsley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 174 E. Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 24 1947, at 5p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 24, 1947, to Aug. 24, 1947

and that I last saw him alive on Aug. 24, 1947

Immediate cause of death.....

chronic myocarditis

DURATION

6 years?

Due to..... arteriosclerosis

Due to..... sensitivity

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... H. W. Billingsley, M.D.

Date signed 8-25-47

RECEIVED

AUG 27 1947

F. T. A. U. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06897

CERTIFICATE OF DEATH

52b
80

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Redford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife.....

Jane Garland

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

88

0

26

hrs.

min.

9. Birthplace.....

(Town, county and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Retired

MOTHER

FATHER

12. Name.....

Lewis Garland

13. Birthplace.....

North Carolina

14. Maiden name.....

Loisia Honeycut

15. Birthplace.....

North Carolina

16. Informant.....

Jess Garland

Address.....

Redford, Md.

17. Burial.....

Burial Date thereof Aug 13-47

(Burial, cremation, or removal. Which?)

(month (day) (year))

Cemetery or crematory.....

Bethesda Cemetery

Location.....

Bachmans Valley Rd.

18. Funeral director.....

K. L. Hartlitz & Sons

Address.....

Elmon Budget New Windsor, Md.

19. Date rec'd by registrar.....

Aug 12 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 11 1947 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 10 1947 to Aug 10 1947

and that I last saw him alive on Aug 10 1947

Immediate cause of death.....

Agent Cardiac Dilatation 12 hrs

Due to..... Chronic myocarditis 3 yrs

Due to..... Cancer of Bladder 6 mos

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Chas R. Trout, M.D. or other

Address..... Westminster, Md. Date signed 8-12-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06898

93d

bc

Reg. Dist. No. 24

24

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 1 mo 12 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution? 3 yrs 1 mo 12 da

3. (a) FULL NAME

Sarah C Garrick

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

J

W

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

June 18th - 1866

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county and state)

10. Usual occupation.

honey work

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8-23-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

(Date paid by registrar)

C. Harry Green

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Unknown

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 19th 1947 at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 20th 1947 to Aug 19th 1947
and that I last saw her alive on Aug 19th 1947

Immediate cause of death

Bronchitis Pneumonia 3da

Due to

chronic Myocarditis

Due to

Senile Arterial Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

AUG 23 1947

BUREAU V & B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06899

CERTIFICATE OF DEATH

93d
81

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Carroll

Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Lifetime

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

William E. Gilbert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Sadie C. Gilbert

7. Birth date of deceased (mo., day, yr.)

Sept. 15 - 1881

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

65

11

18

hrs. min.

9. Birthplace

Frederick County, Md

(Town, county, and state)

10. Usual occupation

Cement Plant

11. Industry or business

Employee

12. Name

Clay Gilbert

13. Birthplace

Maryland

14. Maiden name

Adelaide McLean

15. Birthplace

Maryland

16. Informant

Sadie C. Gilbert

Address

Union Bridge, Md

17. Burial

Date thereof Aug. 28-47

(Burial, cremation, or removal. When?)

(month) (day) (year)

Cemetery or crematory

Lutherson Cemetery

Location

Uniontown, Md

18. Funeral director

H. H. Hartman & Sons

Union Bridge & New Windsor, Md

19. (Date rec'd by registrar)

Aug. 27, 1947

P. Eichman

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

213-03-1037

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 26

1947

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

See. 30 - 1945

1947

to Aug. 26

1947

and that I last saw h.w.m. alive on Aug. 26

1947

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

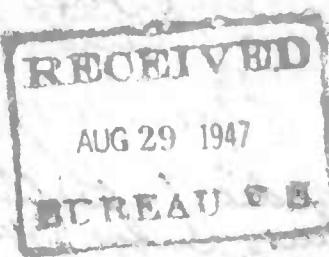
J. N. Legg

M. D. or other

Address Union Bridge

Date signed Aug. 26, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06900

CERTIFICATE OF DEATH

182
Reg. Dist. No. 76

1. PLACE OF DEATH:
County..... Carroll
City or town..... Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Carroll
City or town..... Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 E. Green St.
(If rural, give LOCATION)

2.(a) If veteran, name war..... none

3. (a) FULL NAME

HARRY K GILES

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 23, 1891

8. AGE: Years Months Days If less than one day
56 1 0 hrs. min.9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Hotel clerk

11. Industry or business

FATHER 12. Name..... John T. Giles

13. Birthplace..... Baltimore, Md.

MOTHER 14. Maiden name..... Katherine Kelly

15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. Margaret Reynolds

Address..... Baltimore, Md.

17. burial Date thereof..... 8/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cathedral Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Chas. F. Evans

Address..... Baltimore, Md.

19. (Date rec'd by registrar) 8/23/47

Registrar

3. (b) Social Security Number

216-22-8635

MEDICAL CERTIFICATION

Prior to
20. DATE OF DEATH..... August 23, 1947, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Suffocation

Due to Epilepsy. - Had an epileptic seizure while lying face down, with

Due to Epilepsy. - Had an epileptic seizure while lying face down, with

Other conditions

8/17/42-47

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

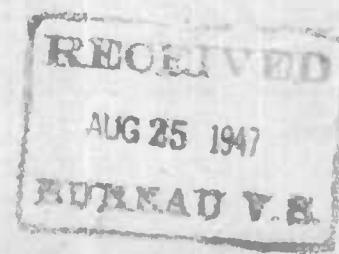
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURES James T. March, Deputy Medical Examiner

M. D. or other

Address..... Westminster, Md. Date signed 8/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06901

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH:

County

Carroll Co.

City or town

Rural near Westminster, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bertha Irene Grabill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f.

w.

Married

6. (b) Name of husband or wife

R. Eugene Grabill

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo. day, yr.)

July 23 1886

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Union Bridge, Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

Jacob Hays

MOTHER

Maryland

FATHER

Julia A. Brushour

MOTHER

Maryland

FATHER

Dr. R. Eugene Grabill

Address

Westminster # R-07 Md.

FATHER

MOTHER

RECEIVED

SEP 2 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06902

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Jan 8 mo 16 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

Jan 8 mo 16 da

3. (a) FULL NAME

Rosco B Grossnickle

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 8 - 1888

6. (c) If alive, give age..... years

8. AGE: Years

58

Months

1

Days

14

If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

Meyersdale

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 4, 1947

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date record by Registrar

20. Signature

Address

21. Means of injury

22. Signature

Address

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 1st 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 16 1945 to Aug 1st 1947

and that I last saw him alive on Aug 1st 1947

Immediate cause of death

Coronary Occlusion

Due to

Cerebral

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Copy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

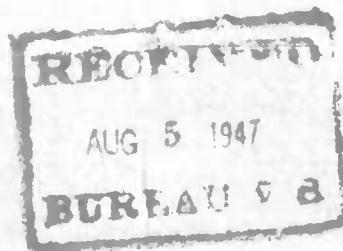
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

06903

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH: Carroll
 County: Carroll
 City or town: Frengelsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, Institution, or street address where death occurred.

How long in hospital or institution?

3. (a) FULL NAME

Jacob Andrew Haines
 4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widower

6. (b) Name of husband or wife: Ella M. Haines7. Birth date of deceased (mo., day, yr.): March 20 - 1862 6. (c) If alive, give age: years8. AGE:

Years	Months	Days	If less than one day
85	4	13	hrs. min.

9. Birthplace: Carroll County, Md (Town, county, and state)10. Usual occupation: Farmer11. Industry or business: Retired12. Name: Samuel A. Haines13. Birthplace: Maryland14. Maiden name: Amanda Bair15. Birthplace: Maryland16. Informant: Walter T. HainesAddress: Bluontown, Md.17. Burial: Burial Date thereof: Aug. 5-1947
 (Burial, cremation, or removal. Which)Cemetery or crematory: Pipe Creek CemeteryLocation: Bluontown Road18. Funeral director: Al B. Hartdee & SonsQueen Bridge & New Windsor Md19. Aug. 5 - 1947 Date reg'd by registrar: Margaret R. Englar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: CarrollCity or town: Frengelsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

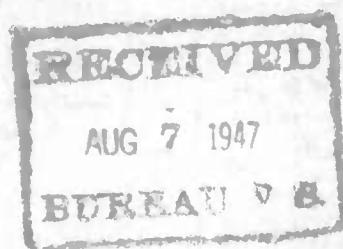
20. DATE OF DEATH: August 2 1947 at 4:00 ³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1947 to Aug 2 1947and that I last saw h. alive on Aug 1 1947Immediate cause of death: Paroxysm of 8 week durationDue to: Due to: Other conditions:
 (Include pregnancy within 3 months of death)Major findings of operations: Date of op.: Autopsy results:
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury: Injured at work? 23. SIGNATURE: James T. Morel M. D. or other: Address: Montgomery St Date signed: 8/3/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06904

136
OC
Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 6 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

Section A

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3060 Ascention Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

3. (a) FULL NAME

LORRAINE HAMLIN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

colored

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

December 8, 1928

8. AGE:

Years

Months

Days

If less than one day

18

7

24

hrs.

min.

9. Birthplace

Leakville, N.C.

(Town, county, and state)

10. Usual occupation

Scholar

11. Industry or business

Clarence Hamlin

MOTHER FATHER

12. Name

North Carolina

13. Birthplace

Ethel Sander

14. Maiden name

North Carolina

15. Birthplace

Deceased

16. Informant

Address

Burial

Date thereof

8/4/47

17. Cemetery or crematory

Mt Calvary

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Location

Brooklyn

J. D.

Grayce Wilson

18. Funeral director

1003 Bryant Ave

Address

8/1/47

19. (Date rec'd by registrar)

Alfred S. Smith

Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947 at 10.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1947, to August 1, 1947, and that I last saw her alive on August 1, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Jan. 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffmaier, M.D.

M. D. or other

Address

Henryton, Md.

Date signed

8/1/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06965

74

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County. Carroll

City or town. Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 1 day

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. Maryland County.

City or town. Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1617 Lombard Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Evelyn Bernice Hardy

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female col. single

6.(b) Name of husband or wife.

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

February 18, 1927

8. AGE: Years Months Days If less than one day

20 6 13 hrs. min.

9. Birthplace. Simpson, N. Carolina

(Town, county, and state)

10. Usual occupation. None

11. Industry or business

12. Name. Mc Kinley Hardy

13. Birthplace. Unknown

14. Maiden name. Helen Gatlin

15. Birthplace. Unknown

16. Informant. Deceased

Address

17. Burial, cremation, or removal. Which? Skipped Date thereof. 9/2/47

Cemetery or crematory

Location. Greenbriar, Md.

18. Funeral director. Mr. George Kelton

Address. 1303 Prestonman St. Balt

19. August 31 1947 Alford R. Smith, Jr.
(Date rec'd by registrar)

Local Deputy Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH. August 31 1947, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1946, to August 31 1947, and that I last saw her alive on August 31 1947.

Immediate cause of death. Tuberculous Peritonitis DURATION June 1946

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

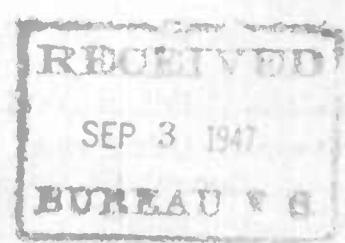
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE. Neuber Hoffman, M.D. M. D. or other

Address. Henryton, Md. Date signed. 8/31/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06906

CERTIFICATE OF DEATH

93a
Reg. Dist. No. 81

1. PLACE OF DEATH:

County

City or town

Carroll
Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Burial

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Day

If less than one day

58

11

3

hrs.

min.

9. Birthplace

(Town, county, and state)

Carroll County, Md.

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

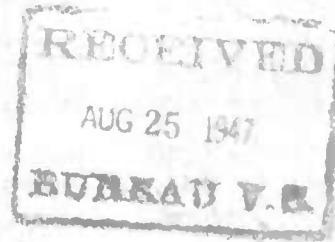
Cemetery or crematory

Location

18. Funeral director

19. Date record by registrar

Date of



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06907

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 5 mos., 30 days

Hospital, institution, or street address where death occurred:

Springfield State Hosp.

How long in hospital or institution? 14 yrs., 5 mos., 30 days

3. (a) FULL NAME

LEONA HOWSARE

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Emory Howsare

6. (c) If alive, give age unkn. years

7. Birth date of deceased (mo., day, yr.)

March 15, 1911

8. AGE:

Years 36

Months 4

Days 26

If less than one day

hrs. min.

9. Birthplace

Clarksburg, W. Va.

(Town, county, and state)

10. Usual occupation

Housewife

own Home.

11. Industry or business

MOTHER FATHER

12. Name

David Keefer

13. Birthplace

unkn.

14. Maiden name

Sarah

15. Birthplace

unkn.

16. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 14, 1947

(month) (day) (year)

Cemetery or crematory Springfield Hosp. Cemetery

Location

Sykesville, Md.

18. Funeral director

C. H. Weer

Address

Sykesville, Md.

Aug. 14, 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH

August 10

1947

12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1947, to August 10, 1947, and that I last saw her alive on August 10, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 yr.

Due to

Due to

Other conditions

Psychosis with Epilepsy

(Include pregnancy within 3 months of death)

15 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arnold H. Eichert M.D.

M.D. or other

Springfield State Hosp.

Date signed 8/10/47

RECEIVED

AUG 18 1947

BUREAU F B I

06908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll

City or town... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 month, 14 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

RUDELL HUMANE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

colored

married

6.(b) Name of husband or wife

Beatrice Humane

7. Birth date of deceased (mo. day, yr.)

February 13, 1903

6.(c) If alive, give age 37 years

8. AGE: Years

Months

Days

If less than one day

44

6

5

hrs.

min.

9. Birthplace

Cambridge, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

Sylvester Humane

13. Birthplace

Maryland

14. Maiden name

Cassia Roberts

15. Birthplace

Maryland

16. Informant

Deceased

Address

17. Burial

Date thereof Aug 21, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Waugh Cemetery

Location

Cambridge, Md.

18. Funeral director

Herbert Mathews & Son

Address

Cambridge, Md.

19. 8/18

19. 47

Date rec'd by registrar

Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Dorchester

City or town... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No... 224 High Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1947, 9.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1946, to Aug. 18, 1947, and that I last saw him alive on August 18, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Feb. 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 8/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06909

CERTIFICATE OF DEATH

138
oc
Reg. Dist. No.

74

1. PLACE OF DEATH:

Carroll

County.....

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 mo.

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis San.

Colored Branch, Henryton, Md.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State.....

County.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

932 Madison Ave.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Lillian Rivers Jenkins

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

col.

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb. 25, 1921

8. AGE:

Years
26Months
6Days
0If less than one day
hrs. min.

Charleston, S. Carolina

9. Birthplace.....

(Town, county, and state)

Domestic

10. Usual occupation.....

Joseph Jenkins

S. Carolina

MOTHER FATHER

12. Name.....

13. Birthplace

Susie Rives

14. Maiden name.....

S. Carolina

15. Birthplace.....

patient

16. Informant.....

Address

Shipped

Date thereof. August 30 1947
(month) (day) (year)

Cemetery or crematory.....

Location..... Charleston, S. Carolina

18. Funeral director.....

Mrs. Sam'l. J. Temple

Address

578 W. 15 Colgate St.

19. 8-25-47

19.

(Date rec'd by registrar)

Albert R. Swank

Registrar

23. SIGNATURE.....

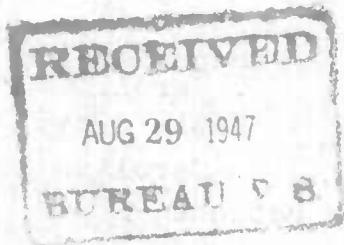
Reuben Hoffman, M.D.

M. D. or other

8/25/47

Address.....

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Supply every item of information carefully. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06910

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution? 13 Days

3. (a) FULL NAME

Henry Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

colored

Widowed

6. (b) Name of husband or wife.

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 28, 1880

8. AGE: Years

Months

Days

If less than one day

67

20

hrs.

min.

9. Birthplace Buhl, Alabama

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Alice Unknown

15. Birthplace Unknown

16. Informant Deceased

Address

17. Burial Burial Date thereof 8/20/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cemetery or crematory

Location

Location

18. Funeral director

Funeral director

Address

Address

19. Aug. 17, 1947

(Date rec'd by registrar)

Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 W. Hill Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 4 1947 to August 17 1947

and that I last saw him alive on August 17 1947

Immediate cause of death

Pulmonary Tuberculosis

DURATION

10/26/45

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

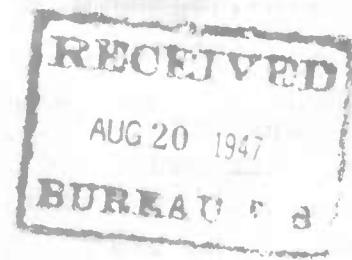
Injured at work?

23. SIGNATURE

Reubenoffman, M.D.

M.D. or other

Address Henryton, Md. Date signed 8/17/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06911

CERTIFICATE OF DEATH

pc
Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution: Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Walton Court
(If rural, give LOCATION)
2.(a) Is veteran, name war:

3. (a) FULL NAME

BURETT KEATON

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife: Lula Keaton

7. Birth date of deceased (mo., day, yr.) May 4, 1893
6.(c) If alive, give age 52 years

8. AGE: Years 54 Months 3 Days 9 It less than one day
hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Building Constructor

11. Industry or business

MOTHER FATHER 12. Name: John Keaton
13. Birthplace: North Carolina

14. Maiden name: Jane Huston
15. Birthplace: North Carolina

16. Informant: Deceased

Address

17. Burial: Date thereof: 8/16/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arbutus Memorial

Location: Elroy D. Wilson

18. Funeral director: Address: 1000 Brantley Ave

Address

19. Date rec'd by registrar: 8/13 1947

Deputy Local

Registrar

3. (b) Social Security Number

212-05-5268

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1947, at 11.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947, to Aug. 13, 1947, and that I last saw him alive on August 13, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Oct.
1945

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mans of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address: Henryton, Md. Date signed: 8/13/47

RECEIVED

AUG 18 1947

BUREAU P 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06912

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

WADE KENNEDY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

colored

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 5, 1905

8. AGE:

Years

Months

Days

If less than one day

41

11

28

hrs.

min.

9. Birthplace

(Town, county, and state)

Columbia, South Carolina

10. Usual occupation

Plumber

11. Industry or business

MOTHER FATHER

12. Name

John Kennedy

13. Birthplace

South Carolina

14. Maiden name

Esther Hawkins

15. Birthplace

South Carolina

16. Informant

Deceased

Address

17. (Burial, cremation, or removal. Which?)

Date thereof 8/6/47
(month) (day) (year)

Cemetery or crematory Baltimore City Cemetery

Location Baltimore Maryland

18. Funeral director Mrs Samuel J. Henry

Address 528 W. Braddock St.

19. 8/2 1947

(Date rec'd by registrar)

Albion P. Swanson
Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 302 N. Pine Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

218-09-5566

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 2, 1947, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1947, to August 2, 1947,

and that I last saw h. im. alive on August 2, 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Feb.

1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

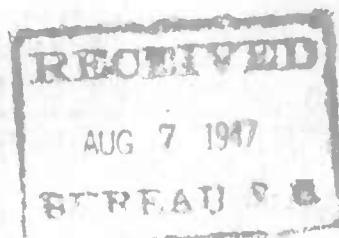
Injured at work?

23. SIGNATURE

Neelie Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 8/2/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06913

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Ignatius Little

3. (b) Social Security Number

112-05-5894

4. Sex Male Color or race White Marital status Married

6. (b) Name of husband or wife Linda A. Little

7. Birth date of deceased (mo., day, yr.) Oct. 10-1892

8. AGE: Year 54 Month 9 Days 29 If less than one day hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Lineman Ret.

11. Industry or business Les & Eddie Co.

12. Name Florence P. Little

13. Birthplace Carroll Co. Md.

14. Maiden name Gertrude Brangie

15. Birthplace Maryland

16. Informant Gertrude Hall

Address Westminster, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Aug 12 1947 (month) (day) (year)

Cemetery or crematory Gladewater Cemetery

Location Westminster, Md.

18. Funeral director H. Burkhardt & Son

Address Westminster, Md.

19. Date rec'd by registrar 8/11/47 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Carroll Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. 2 South George

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to August 9 1947 and that I last saw him alive on August 9 1947.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

years

Due to

Due to

Other condition

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. March

Address Westminster

M. D. or other

Date signed 8-11-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06914

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH:

County

Carroll

Westminster 3rd

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Albert Magruder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m Colored married

6. (b) Name of husband or wife

Bertha Murdock

7. Birth date of deceased (mo., day, yr.)

March 10 - 1878

6. (c) If alive, give age 63 years

8. AGE:

Years 69 Months 4 Days 23 hrs. min.

9. Birthplace

Frederick Co. Md.

(Town, county, and state)

10. Usual occupation

Labour

11. Industry or business

MOTHER FATHER

12. Name

Braceon Magruder

13. Birthplace

Virginia

14. Maiden name

not known

15. Birthplace

.

16. Informant

Bertha Magruder

Address

13 Charles St. Westminster 3rd

17. Burial

Date thereof Aug 6 - 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Fairview Cem.

Location

Baltimore Carroll Co. Md.

18. Funeral director

A. Bankard & Son

Address

Westminster Md.

19. (Date recd by registrar)

19

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legally.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster 3rd

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Charles

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

216-05-9260

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to August 3 1947

and that I last saw him alive on August 3 1947

Immediate cause of death Cerapary

Occlusion

DURATION

1/2 hr

Due to arterio sclerosis severe

& myocardial degeneration pro.

Due to auricular fibrillation

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

Wesley Speicher M. D. or other

Address 13 Charles St. Westminster Md. Date signed 8/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

114d

06915

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 26 days

3. (a) FULL NAME

Mabel Markowitz

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

married

6.(b) Name of husband or wife

Unknown

7. Birth date of deceased (mo., day, yr.)

Unknown

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

.....hrs.min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

14. Maiden name

Unknown

15. Birthplace

16. Informant

Hospital records

Address

17. Burial, cremation, or removal. Which?

Date thereof Sept. 4, 1947
(month) (day) (year)

Cemetery or crematory George Washington Cemetery

Location Cumberland, Md.

18. Funeral director

Arnold H. Eickert

Address Cumberland, Md.

19. Aug 30 1947 O'Hanry Stee

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany Co.

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 25 1947 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947 to August 25 1947

and that I last saw her alive on August 25 1947

Immediate cause of death

Lung Disease

Due to

Due to

Other conditions Schizophrenia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

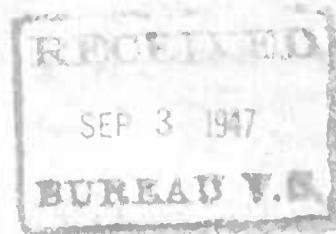
Injured at work?

23. SIGNATURE

Arnold H. Eickert M.D.

M.D. or other

Address 111 Hager, Sykesville, Md. Date signed 8-25-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 138
CERTIFICATE OF DEATH
Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 5 mos. 7 days.
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Centreville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)

3. (a) FULL NAME
Lottie Moody

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August (?) 1876

8. AGE: Years	Months	Days	If less than one day
71	6		hrs. min.

9. Birthplace: Carmichael, Md. (Town, County, and state)

10. Usual occupation: Domestic

11. Industry or business

MOTHER FATHER	12. Name	Joseph Wright
	13. Birthplace	Chestertown, Md.
MOTHER	14. Maiden name	Susie Smallwood
	15. Birthplace	Chestertown, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-22-47
(month) (day) (year)
Cemetery or crematory: St. Luke's Cemetery
Location: Sykesville, Md.

18. Funeral director: Harry Wier
Address: Sykesville, Md.

19. Date of death: August 20, 1947
(Date rec'd by registrar) Local Deputy Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1947, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1947, to August 20, 1947, and that I last saw her alive on August 20, 1947.

Immediate cause of death: Pulmonary Tuberculosis

DURATION: June 1941

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings of operations: _____

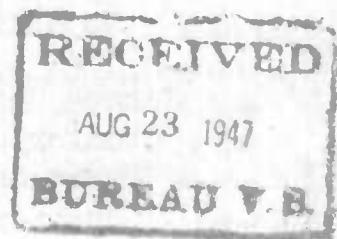
Date of op.: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Neuber Hoffman, M.D. M.D. or other
Address: Henryton, Md. Date signed: 8/20/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06917

93d

Reg. Dist. No. 52

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Carroll

City or town..... Mt. Airy, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ESTHER B. MULLINIX

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife..... Charles Edward Mullinix

deceased

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Oct. 31, 1867

8. AGE:

Years

Months

Days

If less than one day

79

9

24

.hrs.

.min.

9. Birthplace..... Howard Co. Maryland

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

12. Name..... Mahlon Grimm

13. Birthplace..... Maryland

14. Maiden name..... Rachel Gosnell

15. Birthplace..... Maryland

16. Informant..... Mrs. Frank Skeggs

Address..... Mt. Airy, Md.

17. Burial.....

(Burial, cremation, or removal, where?) Date thereof..... 8-28-47

(month) (day) (year)

Howard Chapel

Cemetery or crematory.....

Location..... Long Corner, Howard Co., Md.

18. Funeral director..... C. M. Valtz

Address..... Winfield, Md.

19. Aug 28 47 (Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Carroll

City or town..... Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 25 1947 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 16, 1947, to Aug. 25, 1947

and that I last saw her alive on Aug. 25, 1947

immediate cause of death..... Cerebral Hemorrhage

Duration..... 9

Due to..... Arterio - Sclerosis

Due to..... Hypertension

Other conditions..... Ch. Myocarditis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

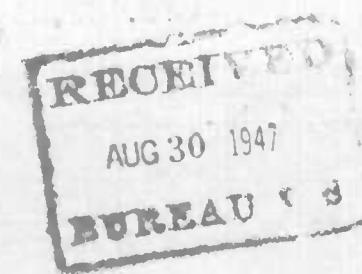
Means of injury..... Injured at work?

23. SIGNATURE..... Stanley Grabill - M.D.

M. D. or other.....

Address..... Notary - Md. Date signed..... 8/26/47

Reg. Dist. No. 52



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

4 yrs 2 mos 25 da

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

89

2

17

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18th 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 24 1943 to Aug 18 1947

and that I last saw her alive on Aug 18th 1947

Immediate cause of death

Cerebral Hemorrhage. I a.m.

Due to

Lumbago, Sclerotic Sclerosis, Myocarditis. 7 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Signature

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06919

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural R/2

(If outside city or town limits, write RURAL and give nearest town)

25 yrs

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Dr Pleasant Valley

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Laura A. Myers

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife J. Theo. Myers

7. Birth date of deceased (mo., day, yr.) May 28, 1871 6. (c) If alive, give age years

8. AGE: Years 76 Months 2 Days 7 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Joseph Helwig

13. Birthplace Md

14. Maiden name Catherine Zepp

15. Birthplace Md

16. Informant Mrs. John Pence

Address Westminister R/2 Burial

17. (Burial, cremation, or removal. Which?) Cemetery or crematory Pleasant Valley Date thereof Aug. 7, 1947 (month) (day) (year)

Location Pleasant Valley, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. (Date rec'd by registrar) 8/5 '47 O. Woodward

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Pleasant Valley (If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Pleasant Valley (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4th 1947 at 6:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1947 to Aug. 4 1947 and that I last saw her alive on Aug. 3rd 1947 1947

Immediate cause of death acute cardiac dilation DURATION 10 days

Due to Cerebral Hemorrhage 10 days

Due to Arterio Sclerotic 5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

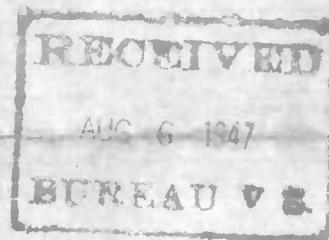
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. C. Foutz M.D. M. D. or other

Address Westminster Date signed 8/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06920

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 4 months

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 18 yrs. 4 months

3. (a) FULL NAME

Mary R. Nickerson

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Married

6. (b) Name of husband or wife William E. Nickerson

6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 11/19/84

8. AGE: Years Months Days If less than one day
62 9 3 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Horney

13. Birthplace Baltimore

14. Maiden name Mary Cassidy

15. Birthplace Baltimore

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial Date thereof 8-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore Cemetery

Location Baltimore, Md.

18. Funeral director Harry J. Zelitsky

Address 4101 Edmondson ave.

19. Aug. 23 1947 C. Harry Zelitsky
(Date record by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH 8/22 19 47, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/22 19 29, to 8/22 19 47

and that I last saw her alive on 8/22 19 47

Immediate cause of death

Pulmonary Tuberculosis

DURATION

3/31/36

Due to

Due to

Other conditions

Involutional Melancholia

(Include pregnancy within 3 months of death)

4/29

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D.

M. D. or other

Address Sykesville, Maryland Date signed 8/22/47

M





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. 'In case of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66923

836

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months - 11 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 6 months - 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Road - Route 3 -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Lester Lee O'Neal

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Angela Grise

7. Birth date of deceased (mo., day, yr.)

September 24-1898 -

6.(c) If alive, give age.....years

8. AGE:

Years 48

Months 10

Days 24

If less than one day

hrs. min.

9. Birthplace

Cumberland - Allegany - Md.

(Town, county, and state)

10. Usual occupation.

Blacksmith

11. Industry or business

MOTHER FATHER

George O'Neal

Cobbler

13. Birthplace

Cobbler

14. Maiden name

Dora Bucky

15. Birthplace

Illinoian

16. Informant

Mrs. Angela O'Neal

Address Cumberland - Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8-20-47
(month) (day) (year)

Cemetery or crematory Sta Peter & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director

John J. Hofer

Address Cumberland, Md.

19. Aug. 18 1947

(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17

1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 6 1947 to August 17 1947

and that I last saw him alive on August 17 1947

1947

Immediate cause of death

Cerebral Embolism and Thrombosis

Due to Pre-frontal lobotomy

DURATION

24 hrs.

Due to

Other conditions Schizophrenia

4 years.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. Virginia Beyer M.D. or other

Address Sykesville, Md.

Date signed Aug. 17-47

RECEIVED

AUG 22 1947

U. S. LIBRARY & B

PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06921

57d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County

Carroll

City or town

Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Thomas Curings

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Rosella Snyder

6. (c) If alive, give age 31 years

7. Birth date of deceased (mo. day, yr.)

March 30. 1902

8. AGE:

45

4

18

If less than one day

hrs.

min.

9. Birthplace

Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

George W. Curings

MOTHER

Martha Caplin

FATHER

Carroll Co. Md.

Maiden name

Birthplace

Birthplace

Name

Burial

Informant

Address

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Funeral director

Address

Means of injury

Signature

Address

Date signed

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

217-12-1984

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1947 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19.

Immediate cause of death Brain tumor

DURATION 24 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Brain tumor

Date of op. 9/28/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James T. Threl, Deputy Medical Examiner M. D. or other

Address 701 W. Pratt Street, Baltimore, Md. Date signed 8/20/47

RECEIVED

AUG 22 1947

BUREAU 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

06924

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

81

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Carroll
Chesapeake Bridge
Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clementine L. Perry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white, widowed
Arthur A. Perry

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

January 31 - 1871

8. AGE:

Years

Months

Days

If less than one day

76 6 24

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Charles Crumbacker

12. Name

Maryland

13. Birthplace

Anna M. Wood

14. Maiden name

Maryland

15. Birthplace

Anna M. Wood

16. Informant

New Windsor, Md. P. O.

Address

Burial Date thereof

Date thereof (month) (day) (year)

(Burial, cremation, or removal, which?)

Fife Creek Cemetery

Cemetery or crematory

Location

Elmwood & Broad

18. Funeral director

H. L. Haubler & Sons

Chesapeake & New Windsor, Md.

Date

Aug 24 1947

Pachman

(Date read by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For ex. born infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 24 1947 to Aug 24 1947

and that I last saw her alive on Aug 22 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

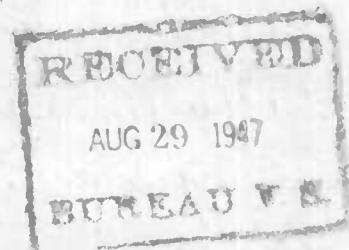
23. SIGNATURE

J. H. Fogg

M. D. or other

Address Kevin Brown Date signed Aug 24 1947

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FEDERAL BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH ~~WASHING~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06925

CERTIFICATE OF DEATH

1860
Reg. Dist. No. 76

1. PLACE OF DEATH:

County..... Carroll

City or town..... Patapsco

(If outside city or town limits, write RURAL and give nearest town)

life

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Wesley Pickett

3. (b) Social Security Number

none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widowed

6. (b) Name of husband or wife..... Sarah E. Pickett

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... July 10, 1859

8. AGE: Years	Months	Days	If less than one day
88	1	5	hrs. min.

9. Birthplace..... Patapsco, Md. (Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business.....

12. Name..... Israel Pickett

13. Birthplace..... Maryland

14. Maiden name..... Susan Fanwell

15. Birthplace..... Maryland

16. Informant..... Mrs. Howard Arbaugh

Address..... Carrollton, Md.

17. burial..... Date thereof..... 8/18/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery..... Carrollton Church of God

Location..... Carrollton, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar)..... 8/6/47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Carroll

City or town.....

Patapsco

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 15 1947 at 3:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26th 1947 to Aug. 15 1947 and that I last saw him alive on Aug. 15 1947.

Immediate cause of death.....

Central Hemorrhage

DURATION

20 days

Due to..... Cardio Vascular disease

15 years

Due to.....

Fall off a wall at home on Aug. 24th following stroke

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

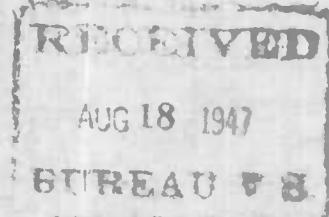
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. J. Billingslea M. D. or other

Address..... Westminster, Md. Date signed..... 8-16-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

06922

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo. 15 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 mo. 15 days

3. (a) FULL NAME

MATRE POLLITT

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife Willa

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	27	hrs. min.

9. Birthplace Wicomico County, Maryland

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Atlantic Mill and Lumber Co.

12. Name Andrew Covington Pollitt

13. Birthplace Wicomico County, Maryland

Brown

14. Maiden name

15. Birthplace Wicomico County, Maryland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial

Date thereof 8-8-47

(Burial, cremation, or removal, which?)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Maryland

Holloway & Co

18. Funeral director

Address Salisbury, Maryland

19. Aug. 6 1947 C. Harry Wee

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5

1947 at 12:10A.M.

March 27 1947 to August 4 1947

and that I last saw him alive on August 4 1947

Immediate cause of death

Arteriosclerotic heart disease

DURATION

7 mos. (known)

Due to Psychosis with cerebral arteriosclerosis

7 mos.

(known)

Due to

Other conditions Diabetes mellitus

7 mos.

(known)

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

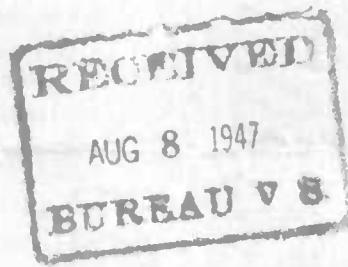
Means of injury

Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.

M. D. or other

Address Springfield State Hospital Date signed 8-5-47



06926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
Carroll
County

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 3 months, 25 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 11 years, 3 months, 25 days

3. (a) FULL NAME

HESTER VIRGINIA POTTS

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
------------------	---------------------------	---

6. (b) Name of husband or wife William H. Potts

7. Birth date of deceased (mo., day, yr.) October 26, 1880

6. (c) If alive, give age years

8. AGE: Years 66	Months 10	Days 5	If less than one day hrs. min.
---------------------	--------------	-----------	--

9. Birthplace Cessna, Pennsylvania
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name William Sleighter

13. Birthplace Bedford, Pennsylvania

14. Maiden name Mary Hall

15. Birthplace Unknown

16. Informant Hospital records

Address Springfield State Hospital

17. Burial, cremation, or removal, Which? Date thereof 9-4-47

(month) (day) (year)

Cemetery or crematory Springfield Hosp. Crem.

Location Sykesville, Md.

18. Funeral director C. Harry Wee

Address Sykesville, Md.

19. Reg. No. 47 Date rec'd by registrar C. Harry Wee

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. #3

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31st 1947 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th 1945 to August 31st 1947

and that I last saw her alive on August 30th 1947

Immediate cause of death

Chronic myocarditis and myocardial degeneration about 3 years

Due to

Due to

Other conditions Schizophrenia, hebephrenic type

more than 12 years
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

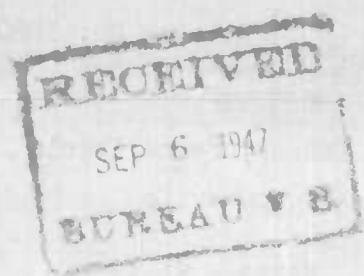
Means of injury Injured at work?

23. SIGNATURE Irene Helleman, M.D.

M. D. or other

Springfield State Hospital Date signed 8-31-47

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06927

CERTIFICATE OF DEATH

93d
Reg. Dist. No. ~~XX~~ 75

1. PLACE OF DEATH:

County

Carroll
Hampstead Md. Rural

City or town. (If outside city or town limits, write RURAL and give nearest town)

35 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

near Greenmount -

How long in hospital or institution?

3. (a) FULL NAME

Jacob William Reed

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Laura Ellen Reed

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 69 years

8. AGE:

Years Months Days If less than one day

66 3 22 hrs. min.

9. Birthplace

Hampstead Md

(Town, county, and state)

10. Usual occupation

Farmer

Agriculture

Edmund Reed

Edmund Reed

MOTHER FATHER

Maryland

Catherine Smith

Maryland

Laura Ellen Reed

Hampstead Md

Burial

Date thereof Aug 9/47

(Burial, cremation, or removal. Which?)

(month day year)

(month day year)

(month day year)

Cemetery or crematory

Greenmount

Carroll Ed Md

Elder T. Hilton

Hampstead Md

Aug 8 1947

Mr. W. P. S. Danner

Registrar

VS A15 9-45-15M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Md Rural

Street No. New Greenmount

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 1947 to Aug 7 1947

and that I last saw him alive on Aug 5 1947

Immediate cause of death Chronic myopathy?

Due to Generalized and Central Nervous System

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

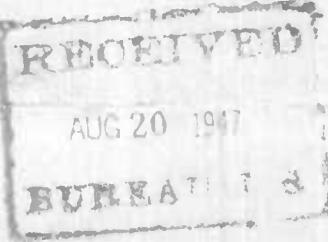
Meane of injury Injured at work

23. SIGNATURE Joseph E. Bush - Md

M. D. or other

Address Hampstead Md Aug 9-47

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06928

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 83

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... Gaither
 (If outside city or town limits, write RURAL and give nearest town) 11 years

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland State..... Carroll County.....
 City or town..... Gaither
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war:.....

3. (a) FULL NAME
 GEORGE DANIEL RHEUBOTTOM

3. (b) Social Security Number
 722-05-5298

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
 male colored married
 Bessie S. Rheubottom

8.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years
 Oct. 22, 1869 75

8. AGE: Years..... Months..... Days..... If less than one day
 77 9 14 hrs. min.

9. Birthplace..... Carroll Co. Maryland
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... B. & O. R.R.
 Samuel Rheubottom

12. Name..... Maryland
 Samuel Rheubottom

13. Birthplace..... Maryland
 Maryland

14. Maiden name..... Mary Cook

15. Birthplace..... Maryland
 Mrs. Bessie S. Rheubottom

16. Informant..... Gaither, Md.

Address..... Burial..... Date thereof..... 8-9-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 White Rock

Cemetery or cemetery..... White Rock
 Location..... Berrett, Carroll Co. Md.

18. Funeral director..... C. M. Waltz
 Address..... Winfield, Md.

19. Date rec'd by registrar..... Aug. 9 1947
 (Date rec'd by registrar) Edua M. Newell Local Registrar
 M. D. or other
 Address..... J. H. Bruno M.D.
 Date signed..... 8/16/47

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 6 1947 at 11 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Aug. 1 1947 to Aug. 6 1947
 and that I last saw him alive on Aug. 5 1947

Immediate cause of death.....
 Carlos Vancutan
 Disease
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings or operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

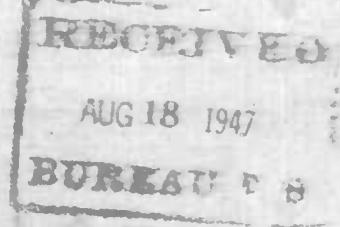
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... J. H. Bruno M.D.
 M. D. or other
 Address..... J. H. Bruno M.D.
 Date signed..... 8/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06929

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 264 E. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME
Raymond E. Rhoten

3. (b) Social Security Number
214-01-0544

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Nola M. Rhoten

7. Birth date of deceased (mo., day, yr.) September 8, 1893

8. AGE: Years 53 Months 11 Days 22 If less than one day hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation Dairy manager

11. Industry or business

MOTHER FATHER
12. Name Charles B. Rhoten
13. Birthplace Maryland

MOTHER
14. Maiden name Martha A. Houck
15. Birthplace Maryland

16. Informant Mrs. Raymond E. Rhoten
Address Westminster, Md.

17. burial burial Date thereof 9/2/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director J. Francis Reese
Address Westminster, Md.

19. 9/1 Date rec'd by registrar 1947 Glennway Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30th 1947 at 147 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10 19. 47 19. 47
and that I last saw him alive on Aug. 30th 1947

Immediate cause of death
Coronary Occlusion

DURATION
4 hours

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Anatomy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. Francis Reese M.D. or other

Address Westminster, Md. Date signed 8-30-47

RECEIVED

SEP 2 1947

FBI - NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06930

830

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 8 mos. 1 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 8 yrs. 8 mos. 1 days

3. (a) FULL NAME

ARTHUR RICE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 24, 1874

8. AGE:

Years

Months

Days

If less than one day

73

6

29

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

12. Name William T. Rice

13. Birthplace Maryland

14. Maiden name Susan Ronston

15. Birthplace Maryland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial

Date thereof 8/25/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Methodist Cemetery

Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 25 Aug 1947
(Date rec'd by registrar)

Harry Teer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Frederick

City or town Jefferson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22

1947, at 1:29 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 1, 1947, to August 22, 1947,

and that I last saw him alive on August 22, 1947.

Immediate cause of death

Pneumonia, hypostatic

Cerebral accident

Due to

Due to

Other conditions Schizophrenia

Arteriosclerosis

(Include pregnancy within 3 months of death)

DURATION

3 days

12 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.

M.D. or other

Address Springfield State Hospital

Date signed 8/22/47

RECEIVED

SEP 3 1947

BUREAU V G

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66931

CERTIFICATE OF DEATH

4665
BC
Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll

City or town... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 10 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 10 days

3. (a) FULL NAME

BERNARD PIUS ROHR

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

WIDOWER

6.(b) Name of husband or wife

Mary Catherine King

(deceased)

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

10/30/79

8. AGE:

Years
67Months
9Days
11

If less than one day

hrs. min.

9. Birthplace

Maryland (Baltimore)

(Town, county, and state)

10. Usual occupation

Office Work

11. Industry or business

12. Name

Joseph A. Rohr

13. Birthplace

Maryland

14. Maiden name

Mary Jane Kennedy

15. Birthplace

Maryland

16. Informant

Record, Springfield State Hospital

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 14, 1947
(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

Baltimore

18. Funeral director

E. Grandstaff

Address

3911 Liberty Night Lane

19. Aug. 13 1947
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...

City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2000 Wetheredsville Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

(DST)

8/11

19. 47

at 11:05 P.M.

20. DATE OF DEATH

7/1/

19.

47.

to 8/11

19.

47.

and that I last saw h. in m. alive on 8/11 19. 47.

Immediate cause of death

Gastric Hemorrhage

DURATION

5 days

Due to Gastric malignancy, type
undetermined

unknown

Due to

Other conditions

Schizophrenia, paranoid type

Since 1916

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Eickert M.D.

M.D. or other

Address Sykesville, Maryland

Date signed 8/11/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66932

75

Reg. Dist. No.

93d

1. PLACE OF DEATH:

County

City or town

Carroll
Manchester 3d R.R. #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Lewis Shaffer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

M

6. (b) Name of husband or wife

Elvorthia (Frances)
November 14, 1894

6. (c) If alive, give age 43 years

7. Birth date of

(Deceased (mo. day, yr.)

November 14, 1894

8. AGE: Years Months Days If less than one day

52 9 11 hrs. min.

9. Birthplace

Carroll Co.

Md.

10. Usual occupation

Retired

Carroll Co.

Md.

Retired (Carroll Co.) 1 year

11. Industry or business

John Shaffer

Shaffer



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66933

CERTIFICATE OF DEATH

93d
Reg. Dist. No.

77

1. PLACE OF DEATH:

County

Carroll

City or town

Hampton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

71 yrs.

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Willella Maxwell Stanbury

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife... Benjamin Franklin Stanbury

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

Feb 28, 1858

8. AGE: Years Months Days If less than one day

89 6 0 hrs. min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name... Willella

13. Birthplace Scotland

14. Maiden name... Elleanor Kelly

15. Birthplace Ireland

16. Informant Miss Mai Stanbury

Address 7 Hampstead, Md

17. Burial Date thereof... Aug 30/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hampstead

Location Hampstead Md

18. Funeral director Edgerton

Address Hampstead Md

Aug 29 1947 John S. Hughes Jr.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(or newborn infants give residence of mother)

State... Maryland County... Carroll

City or town... Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug 28 1947, at 12⁵⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26 1947 to Aug 28 1947

and that I last saw her alive on Aug 28 1947

Immediate cause of death

Crown Myocarditis

DURATION

Due to

Generalized Interstitial

Due to

Other conditions

Pneumonia

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Joseph E. Buel MD

M. D. or other

Address Hampstead Md Date signed 8-28-47

RECEIVED

SEP 1 1947

BUREAU S 8

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06934

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Henryton, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

2½ hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

MARY ANN STAUBITZ

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

Frank Thomas Staubitz

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 21, 1879

8. AGE:

Years
67Months
8Days
0

If less than one day

hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

--

MOTHER FATHER

Unknown

13. Birthplace

Unknown

14. Maiden name

Mary Ann Ruppert

15. Birthplace

Virginia

16. Informant

Reuben Hoffman, M.D.

Address

Henryton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/23/47

(month) (day) (year)

Cemetery or crematory

Freedom

Location

Elkensburg, Carroll Co., Md.

18. Funeral director

C. Harry Wier

Address

Lykensville, Md.

19. Aug. 21, 1947

(Date rec'd by registrar)

Albert R. Schaeffer

Deputy Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Howard

City or town Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 21,

1947

1:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 1947, to Aug. 21, 1947.

and that I last saw her alive on August 21, 1947.

Immediate cause of death

Cerebral hemorrhage

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

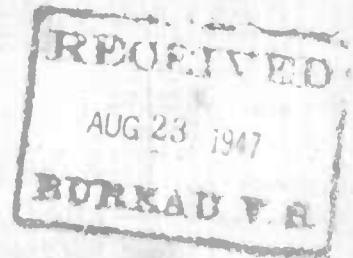
23. SIGNATURE

Reuben Hoffman, M.D.

M.D. or other

Address Henryton, Md.

Date signed 8-21-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06935

CERTIFICATE OF DEATH

97
Reg. Dist. No. 81

1. PLACE OF DEATH:

County.....

City or town.....

Carroll

Elmwood Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Cora A. Stauffer

4. Sex

5. Color or race

6. (a) Single, married, widower, or divorced

female white married

6. (b) Name of husband or wife.....

L. E. Stauffer

7. Birth date of deceased (mo., day, yr.)

July 7-1863

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

84 0 30 hrs. min.

9. Birthplace.....

Carroll County, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

At home

MOTHER FATHER

12. Name.....

Philip Stauffer

13. Birthplace.....

Maryland

14. Maiden name.....

Alice Sheppard

15. Birthplace.....

Maryland

16. Informant.....

L. E. Stauffer

Address.....

Elmwood Bridge, Md.

17. Burial.....

Burial

Date thereof Aug. 9-1947
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Pipe Creek Cemetery

Location.....

Elmwood Road

18. Funeral director.....

El. L. Hartzler & Sons

Address.....

Elmwood Bridge & Elmwood, Md.

19. (Date rec'd by registrar)

Aug. 9, 1947

Registrar

Signature.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... Carroll

City or town..... Elmwood Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 6 1947 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to Aug. 6-1947

and that I last saw her alive on August 6-1947

Immediate cause of death.....

arterio sclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

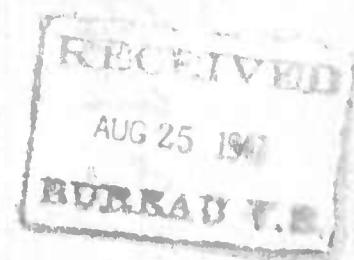
Injured at work?

23. SIGNATURE.....

J. H. Legg

M. D. or other

Address..... Elmwood Bridge Date signed Aug. 6-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

06936

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 4 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11024 Rutland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
William Still

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>colored</u>	6.(a) Single, married, widowed, or divorced <u>widowed</u>
--------------------	---------------------------------	--

6.(b) Name of husband or wife

6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) February 6, 1894

8. AGE: Years <u>53</u>	Months <u>6</u>	Days <u>13</u>	If less than one day
-------------------------	-----------------	----------------	----------------------

5. Color or race colored9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Roofer

11. Industry or business

12. Name Jessie Still13. Birthplace Virginia14. Maiden name Ellen Harris15. Birthplace Virginia16. Informant Sister: Mrs. Lula PughAddress 1811 E. Biddle St. Balt. Md.17. Burial Date thereof 8-22-1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory Mt Calvary Cem.Location Ans Areng Co.18. Funeral director Payne SandersAddress 1412 E. Preston St.19. Date of death August 19, 1947

(Date rec'd by registrar)

20. Deputy Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1947 19. 47, 11:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1947 to August 19, 1947 and that I last saw him alive on August 19, 1947Immediate cause of death Pulmonary Tuberculosis DURATION Jan. 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

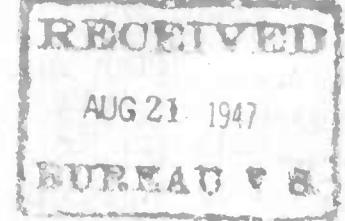
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06937

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:

County

Carroll County

City or town Springfield 8th & Rosedale Streets

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-8-37 till 8-24-947

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? From 1937-1947

3. (a) FULL NAME

Mary M. Strickler

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Nich Strickler

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1880

8. AGE: 67 Years 4 Months 10 Days If less than one day hrs. min.

9. Birthplace

Penns.

(Town, county, and state)

10. Usual occupation

Canvasser

11. Industry or business

Wholesale Wine

12. Name

Austria

13. Birthplace

Ireland

14. Maiden name

Eva Null

15. Birthplace

Ireland

16. Informant

Valentine Strickler

Address 1807 Randolph Ave

17. Burial Date thereof 8-28-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon National

Location Baltimore

18. Funeral director George A. Farley

Address Fult St. & Fayette St.

19. Aug. 29 1947 C. Harry Lee

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

1807 Randolph Ave.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Baltimore

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

24-8 1947, at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 10 1947.

and that I last saw her alive on 23-8 1947.

Immediate cause of death

General exhaustion

Starvation, dehydrated

Due to heart failure

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

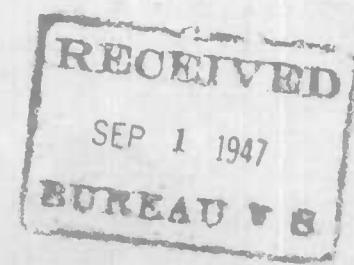
23. SIGNATURE

Dr. H. Salmon

M. D. or other

Springfield Park Hospital Date signed 24-8-47

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06938

CERTIFICATE OF DEATH

46e
Reg. Dist. No. 76

1. PLACE OF DEATH:

County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

34 W Green St.

How long in hospital or institution?

3. (a) FULL NAME

Lewis Abraham Stultz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Rose Fogle

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 10 - 1876

8. AGE:

Years

Months

Days

If less than one day

71

11

28

hrs. min.

9. Birthplace

Carroll County, Maryland

(Town, county, and state)

10. Usual occupation

retired farmer

11. Industry or business

farmer

MOTHER FATHER

12. Name

David Stultz

13. Birthplace

Maryland

14. Maiden name

Elizabeth Stultz

15. Birthplace

Maryland

16. Informant

Thomas D Stultz

Address

New Windsor, Maryland

17. Burial

Aug 17-1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Church of God Cemetery

Location

Uniontown, Maryland

18. Funeral director

DD Hartler & SonsAdd New Windsor & Union Bridge, Md.

19. (Date rec'd by registrar)

8/16 47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster (If outside city or town limits, write RURAL and give nearest town)Street No. 34 W Green Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947 at 8:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 47 to August 14 1947 and that I last saw him alive on August 14 1947

Immediate cause of death

Cerebral (Postural)" (Latent)" (Tonic)

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Jernette, M.D.

M. D. or other

Address W. C. Jernette, M.D. Date signed 8-16-47

RECEIVED

AUG 18 1947

BURKAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06939

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County CarrollCity or town Middlebury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Scott W. Swarts

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 15, 1885

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

61

9

3

hrs.

mto.

9. Birthplace

Spring Water, N.Y.

(Town, county, and state)

10. Usual occupation

Farm Manager

11. Industry or business

12. Name

Jacob O. Swarts

13. Birthplace

N.Y.

14. Maiden name

Mary V. Weidman

N.Y.

15. Birthplace

N.Y.

16. Informant

Mrs. Alta Swarts

Address

Danville, N.Y.

17. Burial

Date thereof Aug. 21, 1947.

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Pleasant Valley

Location

Spring Water, N.Y.

18. Funeral director

C.O. FUSS & SON

Address

Taneytown, Md.

Aug. 20

1947

(Date rec'd by registrar)

Perry M. Rice Powell

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Carroll

City or town

near

Town

Middlebury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 18

1947, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 17

1947

to Aug. 18, 1947

and that I last saw him alive on Aug. 18, 1947

DURATION

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Ligg

M. D. or other

Address Union Bridge

Date signed 8-18-47

RECEIVED

AUG 21 1947

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06940

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

33 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

33 years

How long in hospital or institution?

3. (a) FULL NAME

Mary Tulley

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced single
------------------	---------------------------	--

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 31, 1876

8. AGE: Years 70	Months 7	Days 2	If less than one day hrs.	min.
---------------------	-------------	-----------	--------------------------------------	--------------

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Supervisor of nurses

11. Industry or business

12. Name MOTHER FATHER	unknown
---------------------------	---------

13. Birthplace MOTHER FATHER	unknown
---------------------------------	---------

14. Maiden name MOTHER FATHER	unknown
----------------------------------	---------

15. Birthplace MOTHER FATHER	unknown
---------------------------------	---------

16. Informant friends, Mrs. Frank Ely

Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?)

Date thereof 8-5-47
(month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Ely

Address Sykesville, Md.

19. Aug 11 1947 C. Harry Ely
(Date rec'd by registrar) (Signature) (Signature)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1947 at 8:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1947 to August 2, 1947 and that I last saw her alive on August 2, 1947.

Immediate cause of death

Pulmonary embolism

Due to Chronic myocarditis and myocardial degeneration

Due to about 4 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irene Hitchman, M.D.

M.D. or other

Address Springfield State Hospital Date signed 8-2-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06941

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 months

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

3. (a) FULL NAME

Joseph Maurice Walter4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Bertha Walter7. Birth date of deceased (mo., day, yr.) Oct. 29, 1882 6. (c) If alive, give age years8. AGE: Years 54 Months 9 Days 25 If less than one day hrs. min.9. Birthplace Emmitsburg Md.
(Town, county, and state)10. Usual occupation Tool maker Machinist11. Industry or business Anchor Post Fence12. Name Wm. Walter13. Birthplace Md.14. Maiden name Mary Hopp15. Birthplace Md.16. Informant Bertha WalterAddress Finksburg, Md.17. Burial Burial Date thereof Aug. 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Anthony CemeteryLocation Emmitsburg, Md.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. 1947 8/24/47
(Date recd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

218-01-7027

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 24, 1947, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 8, 1947, to Aug. 24, 1947and that I last saw him alive on Aug. 24, 1947

Immediate cause of death

Coronary occlusion -Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

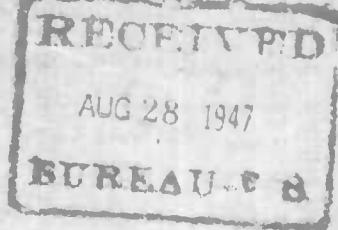
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

James F. Marshall, M.D.M. D. or other
Address Stratford, Md. Date signed 8/24/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06942

CERTIFICATE OF DEATH

Reg. Dist. No. *PC*

1. PLACE OF DEATH:

County

City or town

*Carroll**Manchester Maryland*

(If outside city or town limits, write RURAL and give nearest town)

2 weeks

How long in above place of death?

Hospital, institution, or street address where death occurred:

Long View Nursing Home

How long in hospital or institution?

2 wks.

3. (a) FULL NAME

George Edward Wareheim

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male White Widower*6. (b) Name of husband or wife *Laura A. Wareheim*

7. Birth date of deceased (mo., day, yr.)

Feb. 12, 1858

6. (c) If alive, give age, years

8. AGE:

Years	Months	Days	If less than one day
89	5	25	hrs. min.

9. Birthplace *Middletown, Md.*
(Town, county, and state)10. Usual occupation *Jeweler*11. Industry or business *Self*12. Name *Henry S. Wareheim*13. Birthplace *Md.*14. Maiden name *Matilda Menges*15. Birthplace *Md.*16. Informant *Miss Esta Wareheim*Address *3022 Belmont Ave.*17. Burial *Burial* Date thereof *8/8/47*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery *Woodlawn*Location *Woodlawn, Md.*18. Funeral director *Wm. J. TICKNER & SONS INC.*Address *North & Pa. Aves. Balto. 17, Md.*19. *8-7* Date rec'd by registrar19. *47*a/c. *Regis*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Baltimore Md.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *3022 Belmont ave.*
(If rural, give LOCATION)2. (a) If veteran, name war *None*

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 6 1947 at 5:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23 1947 to Aug 6 1947
and that I last saw him alive on *August 5 1947*

Immediate cause of death

Cerebral Hemorrhage 48 hours

DURATION

Due to

*Arterio-venous Cerebral
vascular disease*

Other conditions

Sensibility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work

23. SIGNATURE

M. D. or other

Address *Humphrey Md.* Date signed *8-6-47*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06945

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
 County Carroll
 City or town Henryton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 mos. 25 days
 Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland county Caroline
 City or town Goldshoro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

213-22-6079

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 47 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 3 19 46 to August 28 19 47
 and that I last saw h. ER alive on August 28 19 47

Immediate cause of death
Pulmonary Tuberculosis

DURATION
Aug.
1945

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings or operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

M. D. or other

8/28/47

Address Reuben Hoffmeyer, M.D. Date signed 8/28/47

3. (a) FULL NAME

Calfreda Warner4. Sex female 5. Color or race col. 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 18, 19278. AGE: Years 20 Months 3 Days 10 If less than one day hrs. _____ min. _____B. Birthplace Greensboro, Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

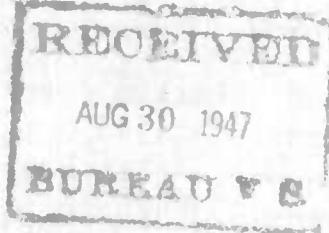
12. Name William Warner13. Birthplace Unknown14. Maiden name Sarah Brown15. Birthplace Unknown16. Informant Deceased

Address

17. Burial Date thereof Aug 31 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory VisionLocation near Greensboro Md.18. Funeral director Raymond B. Rawlings

Address

19. August 28 19 47 Alfred R. Sowden
(Date rec'd by registrar) Local Deputy Registrar



Evidence for the change of year of birth
and age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06943

93d

File No. G 112 AUG 28 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

Carroll

County

Patapsco

City or town

(If outside city or town limits, write RURAL and give nearest town)

1 month

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles August Weaver

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Julia Taylor Weaver

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

March 13, 1896

1890

8. AGE:

57

51

Years

Months

Days

If less than one day

5

1

hrs.

min.

9. Birthplace

Patapsco, Maryland

(Town, county, and state)

10. Usual occupation

retired R.R. Yard Foreman

11. Industry or business

George Weaver

12. Name

Maryland

13. Birthplace

Elizabeth Smith

14. Maiden name

Maryland

15. Birthplace

Mrs. Julia T. Weaver

16. Informant

Hagerstown, Maryland

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/17/47

(month) (day) (year)

Cemetery or crematory

Wesley Chapel Cemetery

Location

near Hampstead, Md.

18. Funeral director

J. Francis Reese

Address

Westminster, Maryland

19. (Date rec'd by registrar)

19 47

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

434 W. Franklin St.

Street No.

(If rural, give LOCATION)

none

2.(a) If veteran, name war

3. (b) Social Security Number

705-10-5539

MEDICAL CERTIFICATION

August 14 47 6 PM

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

Coronary occlusion

DURATION

Due to Cardiosclerosis, disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

James F. Francis Deputy Medical Examiner

M. D. or other

Address Date signed 8/14/47

RECEIVED

AUG 18 1947

BUREAU-F-B-I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06944

CERTIFICATE OF DEATH

B
Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months 26 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 10 months 26 days

3. (a) FULL NAME

John F. Welch

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

?

6. (b) Name of husband or wife

?

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

?

8. AGE: Years

82

Months

?

Days

?

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

?

11. Industry or business

MOTHER FATHER

12. Name

?

13. Birthplace

?

14. Maiden name

?

15. Birthplace

?

16. Informant

Records, Springfield State Hospital

Address

Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8-26-47

(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

Baltimore, Md.

18. Funeral director

C. F. B. Wissel

Address

1300 Eastern Place

19. Date record by registrar

Aug. 24 1947

C. Harry Welch

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 North Monroe Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

(DST)

20. DATE OF DEATH

8/23

19 47 2 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/27

19 46

to

8/23

19 47

and that I last saw him alive on

8/23

19 47

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Due to

Due to

Other conditions

Senile Psychosis, simple deterioration

(Include pregnancy within 3 months of death)

11 months

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

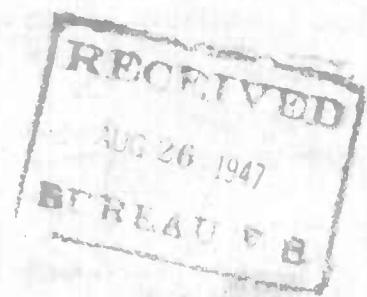
Injured at work?

23. SIGNATURE Arnold N. Eickert, M.D.

M. D. or other

Address Sykesville, Maryland

Date signed 8/23/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06946

CERTIFICATE OF DEATH

528
Reg. Dist. No. 81

1. PLACE OF DEATH:

County

City or town

Carroll

Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frank B. Whitehill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 2-1878

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

St. Louis County, Md.

(Town, county, and state)

10. Usual occupation

Cattle Dealer

11. Industry or business

John Whitehill

12. Name

John Whitehill

13. Birthplace

Maryland

14. Maiden name

Susan Barnes

15. Birthplace

Maryland

16. Informant

Miss Margaret Whitehill

Address

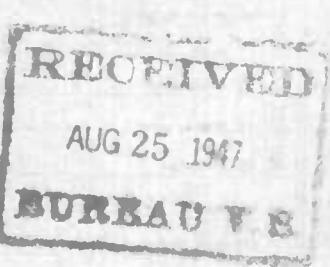
Union Bridge, Md.

17. Burial

Date thereof Aug 21-1947

(Burial, cremation, or removal. Which?)

(Month) (day) (year)



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0694 P.

Reg. Dist. No.

CERTIFICATE OF DEATH

93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

1

9-45-15M

1. PLACE OF DEATH: Carroll
 County: Carroll
 City or town: Springfield State Hospital
If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mos., 29 days
 Hospital, institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 3 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore
 City or town: Baltimore
If outside city or town limits, write RURAL and give nearest town)
 Street No.: 3012 Putty Hill Baltimore - 14
(Rural, give LOCATION)

3. (a) FULL NAME

Bernard Ferdinand Weinhold

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife: Margaret Engelman7. Birth date of deceased (mo., day, yr.) May 16, 18668. AGE: 81 Years 3 Months 0 Days If less than one day hrs. 0 min.9. Birthplace: Baltimore City, Md.
(Town, county, and state)10. Usual occupation: Driver of a delivery trucks

11. Industry or business

12. Name: Frederick Weinhold13. Birthplace: Holland14. Maiden name: Nancy Parker15. Birthplace: Pennsylvania16. Informant: Hospital recordsAddress: Burial17. Date thereof: 8/20/47
(Burial, cremation, or removal, Which?)Location: Holy RedeemerCemetery or crematory: Belair Road, Balto: Md.18. Funeral director: George J. Ruth, Inc.Address: 1735 Harford Avenue19. Date rec'd by registrar: Aug 18 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16, 1947 at 11:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1947 to Aug. 16, 1947, and that I last saw him alive on Aug. 16, 1947.Immediate cause of death: Generalized arteriosclerosis
Arteriosclerotic heart diseaseDue to: Terminal bronchopneumonia 2 daysDue to: 3-4 yearsOther conditions: Psychosis with
cerebral arteriosclerosis
(Include pregnancy within 8 months of death)Major findings or operations: Date of op.Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other Address: Springfield State Hospital Date signed:

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06948

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County **CARROLL**City or town **HENRYTON**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MD. TUBERCULOSIS SANATORIUMHow long in hospital or institution? **3 MOS., 19 DAYS**

3. (a) FULL NAME

WILLIE WILLIAMS

4. Sex

MALE

5. Color or race

COL.

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **DEC. 12, 1902**

8. AGE:

Years **44**Months **8**Days **5**

If less than one day

hrs.

min.

9. Birthplace **New Bern, N.C.**

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

12. Name **Lewis Williams**13. Birthplace **N.C.**14. Maiden name **Mary Deas**15. Birthplace **N.C.**16. Informant **Reuben Hoffman, M.D.**Address **Henryton, Md.**17. (Burial, cremation, or removal) **Burial**Date thereof **8/21/47**

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address **R. Brown****108 W. Montgomery St.**19. **Aug. 17** 19. 47 (Date rec'd by registrar)

Albert R. Brown, Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland**

County

City or town **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **811 Vine Street**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-12-8351

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 17** 19. 47, at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 28 19. 47, to **Aug. 17** 19. 47and that I last saw him alive on **Aug. 17** 19. 47

Immediate cause of death

Pulmonary tuberculosis

DURATION

4/9/47

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address

Henryton, Md.Date signed **8-17-47**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

